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A CASE OF SLOW PULSE.

Read before the Association of American Physicians,
September 25, 1889.

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WITH THE REPORT OF THE AUTOPSY.

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REPRINTED FROM THE THERAPEUTIC GAZETTE, NOVEMBER 16, 1891.

DETROIT, MICH.:
GEORGE S. DAVIS, PUBLISHER.
1891.



A CASE OF SLOW PULSE.

THIS report is to complete the case of "Slow Pulse," previously read before the Association of American Physicians, and which was published in the Proceedings of the Association of American Physicians in 1889 and 1890.*

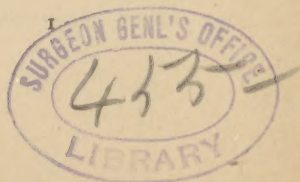
The members may remember that the patient was brought before them for examination, both last year and the year before.

He has since died, and this statement, with the report of the autopsy by Dr. Edes, completes the case.

This man, aged 53 years, had a pulse ranging from 11 per minute to 40 per minute for over two years, being subject to frequent attacks of syncope.

No disease of heart or other organs could be discovered.

* Published in the THERAPEUTIC GAZETTE, December 16, 1889.



The following is the record since last report (May, 1890) :

	P.	T.	
May 20, 1890.	...	...	Became worse; dizzy.
May 24, 1890.	13	97°	Fainting spells almost constant; tightness across chest; no pain; bromide of ammonia; stimulants; morphine and atropine as necessary.
May 26, 1890.	14	...	Only slight spells.
May 30, 1890.	18	...	Only slight spells.
June 10, 1890.	34	100°	Great many spells; has fallen twice, once cutting his head.
June 12, 1890.	15	...	
June 14, 1890.	16	...	Pulse irregular; diarrhoea.
June 19, 1890.	16	...	Few spells; fell.
June 29, 1890.	21	...	More or less delirious for several days.
July 2, 1890.	15	...	Delirious; restless; wanders about house; afraid of being killed.
July 4, 1890.	...	...	Died at 6 P.M.

Had been more delirious and excited than usual; thought several persons were trying to kill him.

Rushed about the house, screaming in terror murder, fire, etc., until the neighborhood was aroused.

Was finally induced to lie down, and seemed quiet.

His wife left him for a few moments, and on returning found him dead.

Autopsy was made by Dr. Edes, and will be reported by him.

AUTOPSY, SEVENTEEN HOURS AFTER DEATH.

Expression tranquil. Body tolerably well nourished; considerable fat under the skin and in cavities. Very little hypostatic congestion. Blood everywhere dark and fluid, except a few small, loose, black clots.

Lungs posteriorly moderately congested, crepitant. No fluid in pleuræ, pericardium, or peritoneum.

Heart rather large and firm. Lungs being well dilated, it is probable that no more than the normal surface of the heart came in contact with the thoracic wall. Neither the aorta nor the coronary arteries were atheromatous.

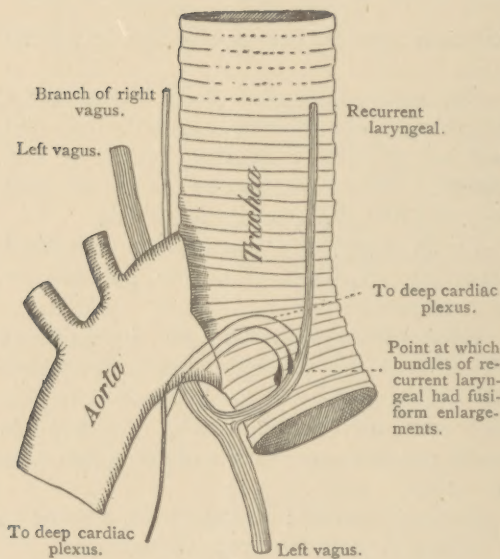
Stomach normal; intestines not opened.

Spleen moderately firm, medium size.

Kidneys congested, capsules not adherent. No atrophy. Healthy.

Brain and upper portion of spinal cord healthy to gross appearance. On the right side, the upper cervical ganglion of the sympathetic, the lower cervical ganglion, a portion of the thoracic sympathetic, a portion of the splanchnic at semilunar ganglion were removed. On the left side, the same portions, except the upper ganglion and the thoracic sympathetic. All these appeared normal to the naked eye.

On dissection of the heart, the left pneumogastric appeared normal until the region was reached where it bends under the arch of the aorta to give off the recurrent laryngeal. Here several of the strands appeared somewhat less clearly defined through



Aorta lifted up to loop of recurrent laryngeal.

the surrounding connective tissue, which at this point was more strongly adherent.

There were fusiform enlargements of the several cords. One of these was on a cord going downward to form the œsophageal plexus; others were on the bend of the recurrent laryngeal just below the artery. At this point the recurrent laryngeal gives off branches which connect with the cardiac plexuses.

The muscular substance of the heart was firm and not fatty. Walls of both ventricles thickened, those of the right perhaps more in proportion to its usual thickness. (See diagram.)

The various portions of the nervous sys-

tem above mentioned were examined microscopically after hardening in osmic acid.

The fusiform enlargements at the point of separation of the cardiac branches from the recurrent laryngeal were so much dragged upon and injured in the process of dissection that the microscopic examination was entirely unsatisfactory and disclosed nothing. The other cords and ganglia, including portions of the cardiac plexuses, showed no increase of connective tissue nor any atrophy either of nerve-fibres or ganglionic cells.

The intrinsic cardiac ganglia I failed to find.

Sections of the medulla were made and stained. Here also the hardening had not been entirely successful, but fortunately the sections at the level of the pneumogastric nucleus were sufficiently good to show that there was no lesion at this suspected point. The most that could be said of the medulla, as a whole, was that it appeared to be congested.

I am much indebted to Dr. Gray, of the Army Medical Museum, for sections of the upper part of the medulla oblongata.

